

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007241
State File No.
Registrar's No. **2 1831**

FILED MAR 10 1959

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. CITY OR TOWN ST. LOUIS Tower Grove	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION FIRMING DESIGNS		STREET ADDRESS (If rural, give location) 1215A Tower Grove	

3. NAME OF DECEASED (Type or Print) a. (First) Barb b. (Middle) Dot c. (Last) Howell	4. DATE OF DEATH (Month) (Day) (Year) 2 19 59
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 2/18/59	9. AGE (In years last birthday) IF UNDER 1 YEAR Months 7 IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Vernon Lee Howell	13b. MOTHER'S MAIDEN NAME Flaine Banta	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Vernon Lee Howell 1215a Tower Grove
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neonatal atelactasia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 762.5			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **2/18**, 19**59**, to **2/19**, 19**59**, that I last saw the deceased alive on **2/19**, 19**59**, and that death occurred at **12:00 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John D. Boushain M.D.	23b. ADDRESS Firming Design, Inc.	23c. DATE SIGNED 2/20/59
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-21-59	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Rolla, Missouri
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DATE REC'D BY LOCAL REG. FEB 20 59	REGISTRAR'S SIGNATURE Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker 4104 Manchester
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Not Embalmed, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed Wm F Heizer
Licensed Embalmer No.
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.